STATE LICENSING COMPLIANCE REPORT

Report #: HL258293242C

Date Concluded: November 17, 2023

Name, Address, and County of Facility Investigated:
The Alton Memory Care
1306 Alton Street
St. Paul, MN 55116
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL258293242C On November 9, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 52 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL258293242C, tag identification 1060, 1070, 1620.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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01060	Continued From page 1 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

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01060	Continued From page 2 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included epilepsy, Alzheimer's dementia with behavioral disturbance, major behavior disturbance, hallucinations, and anxiety. R1's service plan dated April 1, 2023, indicated the resident received assistance with dressing, grooming, bathing, toileting, transfers, behavior management, safety checks, and medication administration. R1's most recent assessment dated May 12, 2023, indicated the resident had recently admitted to hospice and had a history of multiple falls and ongoing behaviors. R1's progress notes indicated the resident fell 26 times in April and May 2023. The resident had	01060		

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01060	Continued From page 3 ongoing episodes of behaviors including being aggressive towards staff and resisting cares. R1's progress notes indicated on May 30, 2023, the resident had three falls that day and the resident's "unstable mood and behavioral issues are contributing to falls. Current behavioral expressions are exceeding facilities (sic) ability to safely provide care for [R1]. PLAN: Sent to ER for evaluation and hopefully a geripsych admission to stabilize behavioral expressions. Will reassess upon return to facility." A progress note dated June 9, 2023, indicated facility staff spoke with R1's daughter and she "wishes for [R1] to be discharged from the Alton and to a higher level of care from the hospital due to her increased care needs at this time." The resident was admitted to the hospital on May 30, 2023, and discharged to another skilled nursing facility on June 21, 2023, after spending 22 days in the hospital awaiting alternative placement. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 4 information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care with in four days that R1 had been relocated and had not returned to the facility. On November 9, 2023, at 5:38 p.m., the investigator requested evidence that an emergency relocation notice was completed and also sent to the Office of Ombudsman for Long-Term Care. On November 9, 2023, at 5:50 p.m., clinical nurse supervisor (CNS)-B confirmed that an emergency relocation notice and notice to the Office of Ombudsman for Long-Term Care had not been completed. On November 17, 2023, at 9:50 a.m., the resident's power of attorney (POA)-C stated they were never given any written notice for the resident's emergency relocation. POA-C stated, "It was a bit of a surprise...we just found out that she doesn't have six months to a year to live, she had weeks to live and her medication was switched to a liquid form and the facility said we can't handle that, we can't take her back, you have 14 days to move her out. We had short notice, we were rushing to get her stuff out within that 14 days plus we've got her sisters and brothers coming to say their goodbyes so it was bad timing on their part and very emotional." POA-C stated they felt pressured to agree to the resident's discharge because "it was worded in such a way from them that it was better for us to move her out in 14 days. They weren't going to take her back and it would have been more money and it was just too much pressure and	01060		

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01060	Continued From page 5 with everything going on with the news we had received, we were so numb and said we'll do it. They preyed on that vulnerability." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one residents (R1) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01070		

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01070	Continued From page 6 Findings include: R1's diagnoses included epilepsy, Alzheimer's dementia with behavioral disturbance, major behavior disturbance, hallucinations, and anxiety. R1's service plan dated April 1, 2023, indicated the resident received assistance with dressing, grooming, bathing, toileting, transfers, behavior management, safety checks, and medication administration. R1's most recent assessment dated May 12, 2023, indicated the resident had recently admitted to hospice and had a history of multiple falls and ongoing behaviors. R1's progress notes indicated the resident fell 26 times in April and May 2023. The resident had ongoing episodes of behaviors including being aggressive towards staff and resisting cares. R1's progress notes indicated on May 30, 2023, the resident had three falls that day and the resident's "unstable mood and behavioral issues are contributing to falls. Current behavioral expressions are exceeding facilities (sic) ability to safely provide care for [R1]. PLAN: Sent to ER for evaluation and hopefully a geripsych admission to stabilize behavioral expressions. Will reassess upon return to facility." A progress note dated June 9, 2023, indicated facility staff spoke with R1's daughter and she "wishes for [R1] to be discharged from the Alton and to a higher level of care from the hospital due to her increased care needs at this time." The resident was admitted to the hospital on May 30, 2023, and discharged to another skilled nursing facility on June 21, 2023, after spending	01070		

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01070	Continued From page 7 22 days in the hospital awaiting alternative placement. On November 17, 2023, at 9:50 a.m., the resident's power of attorney (POA)-C stated they were never issued a termination notice or given any options to allow the resident to return to the facility. POA-C stated, "It was a bit of a surprise...we just found out that she doesn't have six months to a year to live, she had weeks to live and her medication was switched to a liquid form and the facility said we can't handle that, we can't take her back, you have 14 days to move her out. We had short notice, we were rushing to get her stuff out within that 14 days plus we've got her sisters and brothers coming to say their goodbyes so it was bad timing on their part and very emotional." POA-C stated they felt pressured to agree to the resident's discharge because "it was worded in such a way from them that it was better for us to move her out in 14 days. They weren't going to take her back and it would have been more money and it was just too much pressure and with everything going on with the news we had received, we were so numb and said we'll do it. They preyed on that vulnerability." On November 17, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated she had conversations with the hospital and the resident's family when they were "at the point we were not able to meet her needs...she had oral liquid medications, some required refrigeration and we didn't have a way to store those medications in a place the aides had access to if there wasn't a nurse here." CNS-B stated the resident also required an assist of four to five people if she fell and they weren't able to meet those needs. CNS-B stated she had talked to the resident's POA and "I told her we're not able to meet her	01070		

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01070	Continued From page 8 needs because of this and your options are request discharge or we can take her back but we will not be able to meet her needs, so they decided to request discharge." CNS-B stated she did not provide a termination notice because the POA chose to request the resident be discharged. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed assessments as required for one of one residents (R1) with a change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included epilepsy, Alzheimer's dementia with behavioral disturbance, major behavior disturbance, hallucinations, and anxiety. R1's service plan dated April 1, 2023, indicated the resident received assistance with dressing, grooming, bathing, toileting, transfers, behavior management, safety checks, and medication administration. R1's progress notes indicated the resident admitted to hospice services on April 25, 2023. R1's most recent assessment dated May 12, 2023, indicated the assessment was done due to a change in condition with the resident "enrolling in hospice services on 4/26/2023." The reassessment was completed 17 days after the resident experienced the change in condition with her admission to hospice.	01620		

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01620	Continued From page 10 On November 17, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated the change in condition assessment was late because the day she had planned to do the assessment, she realized her nursing license had expired and there was not another registered nurse available to do the assessment that day. CNS-B stated since her nursing license was not renewed, she was not able to work so they had to do the assessment on a day a nurse could come in and do it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		